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THE CHANCRE AND ITS TREATMENT.

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AMONG the most interesting among medical studies, syphilology holds a deserved pre-eminence. Syphilis is so universally disseminated, and it exhibits itself in so many forms, that it never ceases to have a most keen interest for the student of symptomatology and pathology. The advances made in the study of the subject during the past half century are truly marvellous, and reflect not only credit but honor upon the magistral minds which have devoted their energies to a complete elucidation of the subject. After having laid down the broad lines of the subject more special, and particular lines have been taken up, and to-day specialization is holding more or less complete sway, thereby leading to a more complete and profound knowledge of the subject. I do not propose to do more than roughly sketch an outline in this paper, and endeavor to briefly describe the chancre, with some few suggestions of those methods of treatment which I have found to give the best results, so far as a rapid and satisfactory recovery are concerned. To completely elaborate the subject would require space sufficient to fill a volume, and, on that account, only a few of the leading points can be compressed within the limits of a reasonably short article.

The chancre, primary helkosis, primary syphilis, or, as it is erroneously called by some, syphilitic chancre, is the primary expression of a general infection due to an inoculation from syphilitic virus. The question as to whether the chancre is a purely local disease when it makes its appearance, I have already discussed elsewhere,[1] and so will not take it into consideration here. Suffice it to say that the point has been established beyond any reasonable doubt. What I propose to speak of more particularly is the diagnosis of the chancre, the different varieties observed, and the proper treatment to follow. We find that in making a diagnosis, many points are to be remembered, and more particularly not to confound the lesion with chancroid, which is the trouble said to resemble it most closely. As the chancroid rarely, if ever, occurs upon any other portion but the genitalia, its location on any part need cause no confusion, but the general characteristics of the chancre which will be given are applicable to it wherever found, with some possible exceptions, which will be alluded to later on. The principal points of difference may be tabulated as follows:[2]

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[1]Double chancre à distance. *St. Louis Med. and Surg. Jour.*, July, 1892.

[2]See Bumstead and Taylor on Venereal Diseases. In his last edition Taylor does not give this tabulation.

CHANCRE.	CHANCROID.
1. Due to contagion from a syphilitic secretion.	1. Due to infection from a chancroid or chancroidal bubo or lymphitis.
2. Incubation from two to three weeks.	2. Within a week.
3. Generally single; if multiple, all of same age.	3. Often multiple and of different ages.
4. Superficial flat, elevated, or "scooped out."	4. Deep, excavated, and "punched out."
5. Sloping, flat or rounded adherent edges.	5. Abrupt, sharply cut, eroded, undermined.
6. Red, livid or copper-colored floor, smooth.	6. Whitish, grayish, pultaceous, "worm-eaten."
7. Secretion is scanty and serous.	7. Abundant and purulent; auto-inoculable.
8. Induration of base.	8. Infiltration more or less marked.
9. No pain, or very little.	9. Painful.
10. Phagedena, rare and limited.	10. Often takes on phagedenic action.
11. Generally occurs but once.	11. May occur an indefinite number of times.
12. Induration of lymphatics common.	12. Inflammation of lymphatics rare.
13. Lymphatic glands indurated; suppuration rare; multiple bubo.	13. When reaction occurs it is inflammatory and often suppurates; single bubo.
14. Peculiar to human race.	14. Transmissible to lower animals.
15. A constitutional disease.	15. Always a local affection.

These constitute the principal points of difference, but it must be borne in mind that there are different degrees of induration, and the distinction must always be remembered between it and infiltration. It is not only the chancre proper which is indurated by a narrow zone surrounding it is also implicated. The chancre may begin as an erosion, a papule, a pustule, or rarely a vesicle. The induration may be cartilaginous, parchment-like or barely perceptible. To properly appreciate this sign delicacy of manipulation is absolutely essential. The location of the chancre governs the variation in intensity of induration to a considerable degree, and on the mons veneris a chancre may occur which, to all intents and purposes, does not present any induration whatever. Whilst many lay great stress upon the pathognomonic value of a "hard" sore, it may be very deceptive to even an experienced investigator, and should not be depended upon solely as an infallible guide. A case in point may serve to illustrate this better, and also show the care which should be taken against falling into a fatal error.

The following is a case illustrative of the possibility of error which may creep in a case, unless great care and discrimination be employed. And it may be safely laid down as a rule, that until as exact a method of making a diagnosis of syphilis as we already possess for tuberculosis is found, no one, however expert he may be, or however much experience he may possess, can be justified in making the claim of total exemption from or liability to err in pronouncing positively upon the nature of a suspected chancre. The case I desire to mention occurred in a young man who stated that he had a "chancre" upon his prepuce. It appeared about three

weeks after the suspicious intercourse. The lesion was situated on the internal surface of the upper part of the prepuce, and was about the size of the small finger-nail. It had a roundish appearance, and had a distinctly

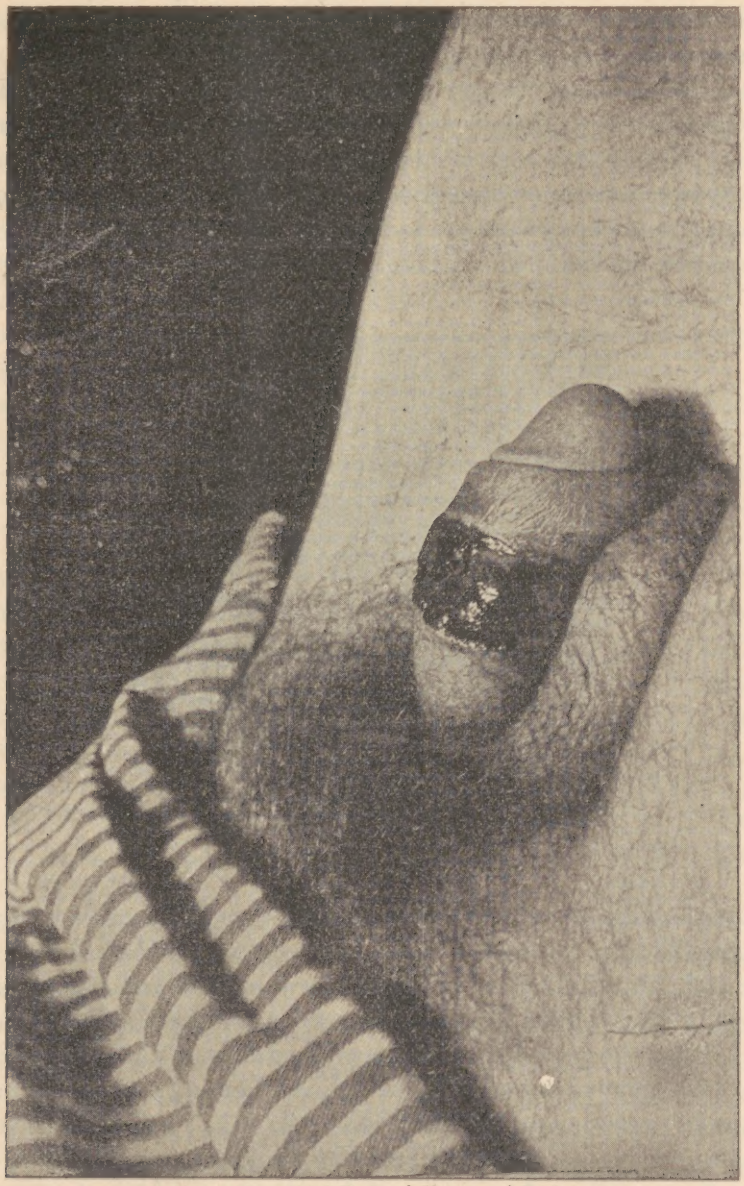

FIG. 1. Dry-Patch Form of Chancre of Penis

cartilaginous feel. It could be freely moved, and its boundaries could be distinctly made out. Its surface was glazed, and no secretion could be made out. No particular pain was felt in connection with. The inguinal adenitis was obscure, and far from classical. The glands could hardly

be made out, and this led me to entertain a serious doubt as to its being a chancre. The headache which existed was not the peculiar cephalalgia typical of syphilis. I had an opportunity of practicing confrontation, and the woman did not present a single symptom of syphilis. Under simple astringent treatment, the "chancre" diappeared in about two weeks, and not a single sign of syphilis has shown itself since that time, some four years ago. About a month ago when I last saw him, he was still free of all hectic symptoms. Now, I will venture to assert that almost any syphilologist examining this case would have pronounced it a chancre, unless his suspicions had been awakened like mine were. The eventual course of the lesion showed the induration to be false, and the lesion was a pseudo-chancre. This is the true pseudo-chancre, and more deserving of that

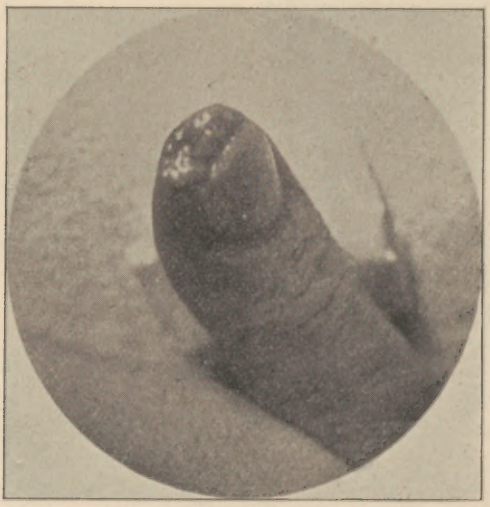

FIG. 2. Fungating Chancre of the Thumb.

appellation than the chancroid which is hardly deserving of that name when we consider that the distinctive signs are so distinct and clear-cut.

The different varieties of chancre are numerous and varied, although they nearly all possess the general characteristic features which have been given. Among the principal varieties observed upon the penis are the following: The chancrous erosion of which the herpetiform, parchment-like, and indurated nodule are sub-varieties; the silvery spot, which is also known as the desquamating form; the dry papule or patch which is quite common; the umbilicated papule, nodular papule, or follicular form, which is rare; the purple necrotic papule; the ecthymatous chancre; the parchment chancre; the annular chancre; and the diphtheritic chancre, an extremely rare form of lesion. At the vulva, the same varieties are to be found, and the vagina is the seat of the encrusted chancre, whereas at the

posterior commissure may be occasionally seen the *chancre en cocarde*. The fingers are attacked by different varieties, which are somewhat dissimilar to any which have been mentioned, such as the fungating chancre, the excoriated or exulcerated nodule, the panaritium-like chancre, etc. From this rather summary enumeration, it will be readily perceived that the study of the clinical characteristics alone would form a respectably sized monograph, and would occupy much more space than I can devote to it here. It is on account of this reason that the pathological anatomy of this lesion will not be entered upon. Suffice it to say that it consists essentially of a round cell infiltration of the tissues subjacent to the lesion, and projecting somewhat beyond it, forming thus a narrow peripheral zone. The greater or less amount of infiltration produces the different intensity in induration. This peculiar cellular infiltration is also responsible for the induration of the lymphatic vessels and glands which is encountered as an accompaniment of the chancre.

So far as the location of the chancre is concerned, we may divide it into two great divisions—genital and extra-genital. The chancre is located at the point where infection occurred, and may be either of venereal or non-venereal origin. In regard to the latter but little can be said in addition to what Dr. L. D. Buckley has given us in his classical work on the subject.[1] The chancre may occur at any point on the skin, at the openings of mucous outlets, and on accessible portions of mucous membranes. To give a mere list of all the localities where the chancre has been observed would require more space than the limits of this article would justify. In Figure 1 is given an example of that form of chancre known as the dry patch, occurring on the sheath of the penis, a rather unusual location, in view of the fact that when that organ is affected it is the prepuce, glans or urethra, which is usually implicated. The fungating form of chancre is shown in Figure 2, which represents a case that occurred in a waiter employed in a very popular restaurant. The manner in which the infection occurred was unknown to the patient, and it would certainly be useless to endeavor to make any surmises on the subject. An example of the encrusted form of chancre occurring upon the lower lip is shown in Figures 3 and 4. In the former figure the large size of the lesion is well exemplified and its thickness may be judged by the profile view given in the other picture of the same patient. These few examples will certainly suffice to show how different are the appearances presented by the primary symptom of syphilis and how carefully examined each case should be before any positive diagnosis is attempted. Some modifications which are secondary and which have not been mentioned are the serpiginous, the phagedenic and the gangrenous chancre. We also occasionally encounter the relapsing chancre (chancre redux), which may lead to error if a case be not carefully examined, or may be mistaken for a reinfection.

[1] Syphilis Insontium. 1894.

So far as the treatment of the chancre is concerned it should be purely local. The attempt to abort a case of syphilis by general medication administered as soon as the chancre appears is simply a delusion. The best that can be done, according to the warmest advocates of the plan, is either to postpone the appearance of general symptoms or to render them less severe, this latter being a proposition which has never been satisfactorily proven. So far as excision of the chancre is concerned, it has proven a complete failure in my hands as an abortive measure, and the results of others have only served to confirm my own deductions. I will not enter into this question, as I have already sufficiently considered it on a former occasion[1]

FIG. 3. Encrusted Chancre of Lip. Front View.

(1892). For the present it will be sufficient to speak of the local treatment of the chancre.

So far as the local treatment is concerned, the general rules of procedure have always had as their prime objects, cleanliness, suppression of secretion or suppuration, healing, and as rapid a return to the normal as possible. In the case of a simple lesion the use of a $\frac{1}{1000}$ bichloride solution followed by a dusting powder, such as calomel, has been a favorite method and quite a good one too. On the other hand, mercurial plaster or emplastum de Vigo cum mercurio has its advocates to this day. In the ulcerating, herpetiform and fungating forms the same methods have been

[1] *Loc. sit.*

proposed and in those cases in which the chancre is located upon a mucous membrane or in such a cavity, slight cauterization is looked upon as of benefit. Those who are ultra in their ideas, use an ordinary carbolized ointment or iodoform powder in the treatment of these simple forms. In the serpiginous, gangrenous, deeply ulcerating, and other destructive forms, cauterization is properly called for. The subsequent dressings are as given above. Dr. J. Willard Parker Worster speaks highly[1] of the use of a spray of peroxide of hydrogen under a pressure of sixty pounds, using as a subsequent dressing iodol powder. In this connection it may be well to state that whilst calomel is a favorite application, iodol, europhen, aristol, and a large number of other remedies have been claimed to possess most valuable properties for this purpose. However, subnitrate of bismuth, oxide of zinc, starch, and other inert powders are reported to act in a manner just as efficient. One point upon which there seems to be a general consensus of opinion is that mechanical protection to the chancre is advantageous, and this may be obtained by the interposition of a piece of cotton or some equally soft material, which thus prevents friction or any other similar mechanical irritation.

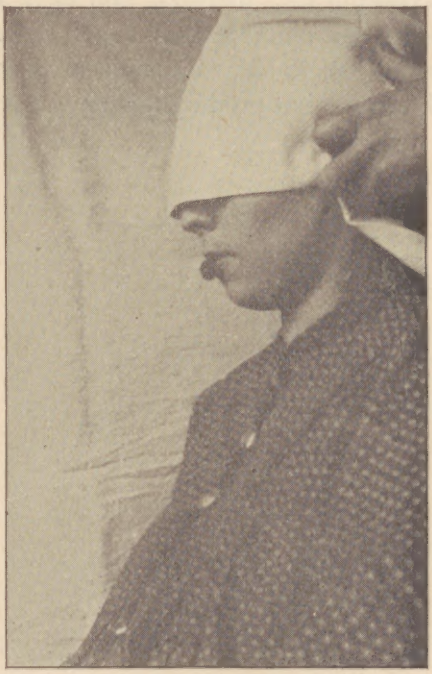

FIG. 4. Encrusted Chancre of Lip. Side View.

In conclusion I desire to detail the methods which I have followed with success, and from which I have had no reason to deviate in the treatment of a comparatively large number of cases. Whilst I do not desire to insist upon my methods being the only good ones, they are so simple in character and of such easy application that I may be pardoned for speaking of them in connection with the subject. In those forms of chancre characterized by a macule, papule, dry scaling papule, abrasion or excoriation, the lesion should be dressed twice daily. It is first cleansed with a $\frac{1}{500}$ solution of bichloride and the following ointment then applied:

℞ Hydrarg. oleat 5%
Ung. hydrarg. ciner., ... aa ℥ss
M.

1 Jour. Cut. & Genito-Ur. Dis., Feb., 1895.

A very thin layer of absorbent cotton is then interposed between the chancre and the opposing surface, whether it be integument or clothing. If the lesion be located in the cavity of the mouth, vagina, or rectum the bichloride solution is first thoroughly applied and nothing further is done, except in the latter two, where the ointment may be applied. Should the chancre show a destructive tendency, cauterization is to be practiced *largo manu*. No middle course should be adopted and no hesitation shown. One thorough cauterization will usually suffice, but it should be efficient. For this purpose I employ either nitric acid, C. P., or pyrozone solution 25 per cent. The dressing is as indicated above. I have never found it necessary to resort to complicated methods and have always had the satisfaction of not only seeing the chancre heal rapidly, but the induration reduces to such a degree and in so short a time that there can exist no doubt of the local mercurial application producing this result.